

# Modern PSAs: A Stable Alignment Model in an Unstable Healthcare Environment

*White Paper*



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## INTRODUCTION AND OVERVIEW

Professional services agreements (PSAs) are a popular alignment model for organizations that seek a stronger partnership with each other but don't want to engage in full employment. As private practices and health systems alike continue to evaluate their options for working together during the continuing evolution of healthcare delivery, the expectations are that PSAs will continue to grow in popularity.

The trend of private practices seeking financial and operational support from health systems is not new to the industry and is prevalent in all specialties and practice structures (i.e., single and multispecialty, hospital-based, and others). Historical transactions have revolved around employment models for stability. However, PSAs have gained ground in the industry as providers realized they could attain that stability level without sacrificing their autonomy and independence.

Moreover, as reimbursement trends continue to shift from volume to value, private practices realize their models may be a more cost-effective solution than hospital-owned entities, though they still seek certain advantages through alignment with an organization of a grander scale. As consolidation in the industry continues and contracts come up for renewal, expect to see migration to these revised models where practices (and their physicians) remain at the helm of decision-making for their practice. Recent trends show an uptick in practices disengaging from their health system employers and starting again as a private practice, with many continuing to partner with that same health system via a PSA.

Nonetheless, the end of employed providers has nowhere near reached its conclusion, and parties must take into consideration the full array of pros and cons when choosing how to align. It is important, however, to know that employment is not the only option. Transactions can take on a whole host of forms based on the nuances of the parties and their intended outcomes, ranging from limited, moderate, and full models as shown in Exhibits I and II (attached).

Just as the model type can vary greatly, so can a PSA itself. PSAs—also known as “employment lite” models, as they mirror some components of employment without full integration—are entirely customizable to fit the specific needs of the partner. Thus, they are typically flexible for almost every situation. Through the completion of hundreds of these transactions, Coker advisors have amassed expertise on the topic through our varied engagements. This experience, combined with our knowledge of the healthcare industry as a whole, has led to a unique position to speak and provide insights on this topic.

## WHAT DO PHYSICIANS AND HOSPITALS NEED AND WANT?

The monumental shift in the healthcare industry over the past ten years to value-based care has altered how all aspects of operations (clinical, financial, operational) are considered and managed. Clinicians and business managers are tasked with driving value—defined as quality per unit of cost—into care delivery. It is more imperative now than ever for providers and organizations to determine a successful method for partnering. For hospitals, it is necessary to have engaged and supportive physicians to drive value from the front lines by leading quality and outcomes initiatives, improving the care continuum, and monitoring costs. Providers must have a full spectrum of resources available, including a robust IT infrastructure, efficient facilities, and qualified support staff. As payers continue shifting the risk to care providers (both the physicians themselves and the facilities), this partnership will be vital for achieving success in these value-based reimbursement structures, such as bundled payments, shared savings/losses programs, etc.

Historically, hospitals sought to employ physicians due to a lack of specialty providers and to meet community demands brought on by recruitment difficulties, especially in more rural areas. Hospitals saw providers as critical to their revenue stream—after all, without quality providers, hospitals are deemed relatively useless. With the healthcare industry’s shift to a more patient-centric model, however, hospitals realize the numerous other benefits that are available from having a partnership with physicians outside of a simple employment agreement. These partnerships seek true integration and alignment of goals through increased collaboration, including participation in clinically-integrated initiatives such as the development of clinically integrated networks (CINs) or accountable care organizations (ACOs). These entities are inherently physician-led and require the full support of physician leaders to be successful. Previously, the most significant factor to alignment was whether it was *fiscally* sound for the hospital. As the industry changes, the current focus is more on whether it is *clinically* sound for the hospital, though economic substantiation is still a prerequisite.

From the practice or independent physician’s perspective, alignment with a partner has always been attractive due to the stability it provides and the ability to focus on the clinical aspects of care, rather than having to be more active in the business functions. These imperatives will continue, and practices must still balance the many competing economic pressures, including increased regulatory demands, administrative and infrastructure needs, decreasing reimbursement rates, and the ongoing burdens of operating a business. Nonetheless, alignment does have the ability to alleviate some of these stresses. Additionally,

physicians can see the potential for alignment models as Stage I, with the longer-term goal of clinical integration being Stage II. Again, as value-based care also brings forth unprecedented challenges and risks, finding a supportive partner will be key to weathering these changes and finding success in this new paradigm.

Regardless of this somewhat uncertain healthcare backdrop, many private-practice physicians desire to maintain as much independence as possible, both clinically and financially. Unfortunately, many have forfeited substantial autonomy by embracing employment. Employment itself has transformed in recent years to allow more flexible and supportive models, i.e., not solely the traditional Internal Revenue Service (IRS) W-2 model. However, if employment does not meet the needs of the hospital or practice, or they are still in the trial phases of assessing compatibility, other options are available to consider that can meet the needs of the two parties. PSAs can be the solution to that problem.

This paper discusses PSAs and how they can achieve a high level of alignment, while still maintaining ownership of the practice for the physicians. Again, there are other options available for integration outside of PSAs, however, this paper is not intended to serve as an overview of all such models. *(Note: For a complete summary of the degrees of alignment, including the PSA employment-lite model, refer to Exhibit I, Alignment Models – Full.)*

## WHAT IS EMPLOYMENT LITE?

Employment is the fullest form of alignment among hospitals and physicians, with employment lite signifying a high level of physician-hospital alignment that falls just short of full employment. It is formalized by a professional services agreement that is specific to this arrangement. The term PSA is not to be confused with other arrangements such as clinical co-management, directorship, or other professional arrangements. Technically, these arrangements may be considered professional services agreements but not in the sense of our definition in this paper. *(Note: There are various forms of physician/hospital integration. Many of these relationships involve a contract—a professional services agreement. Technically, PSAs encompass virtually any agreement wherein a physician provides professional services on a contractual basis. In the context of this paper, however, PSAs refer to the particular alignment relationship that entails many of the aspects of employment, i.e., full integration, without an IRS W-2 employee relationship; hence, the term employment lite.)*

While employment typically entails an IRS W-2 relationship, most PSAs entail an “IRS 1099” relationship. The physicians remain employed by their practice entity, the practice retains its

original ownership, and the organization contracts the physicians for the provision of professional services through the PSA. *(Note: As described below, the practice management arrangement entails physician employment by the hospital. However, the practice entity remains intact in this scenario, and the physicians retain the ability to oversee its management.)* The PSA structure allows for many of the same benefits and elements of employment, while the practice remains an independent contractor rather than an employee. Descriptions of some different models of a PSA are available in the following sections.

## PROFESSIONAL SERVICES AGREEMENT

A PSA between a hospital and a physician practice can fall into four basic scenarios as summarized below and as expounded in subsequent sections. While these models are the foundational and most common and recognized models, each can be modified in countless ways to meet the distinct needs of the organizations. Again, there are no one-size-fits-all alignment structures, particularly pertaining to the PSA. The specific terms will be modified and agreed upon throughout the negotiations process and defined in the agreement. Nevertheless, the general terms of PSAs described below will likely have the core key tenets to serve as a good starting point for those discussions. Regardless, no two PSAs are identical, and each should be thoroughly vetted to ensure it achieves its intended goals prior to the implementation of any agreement.

The following are the most common variants of the PSA model:

1. *Global Payment PSA.* The practice is contracted by an organization to provide professional services in exchange for a global payment rate (typically a rate per work RVU), which encompasses all physician compensation and benefits. The practice also receives reimbursement for its fixed and variable overhead costs. The two parties work together through a joint management committee to adhere to annual budgets and oversee the overall relationship; however, the practice retains control of its practice entity and staff.
2. *Practice Management Arrangement.* The organization employs the physicians. The practice entity stays intact and contracts with the organization for management services. Administrative management staff members are not employed, as the practice provides these services via a management contract (a corollary yet separate agreement from the PSA itself) and receives a corresponding fee set at fair market value.
3. *Traditional PSA.* The organization contracts with physicians (vis-à-vis their historical practice entity) for professional services that are reimbursed

through a rate per wRVU. The organization assumes ownership of the administrative structure of the practice by employing all support staff, performing the billing and collection functions, owning the accounts receivable, etc.

4. *Carve-Out PSA*. Within any of the PSA models explained thus far, provider groups can opt to “carve-out” certain services, locations, specialties/subspecialties, or practice physicians to fall under the PSA. For example, an organization could contract with a private gastroenterology practice for the provision of endoscopies only, or a subset of providers could serve one community hospital with another subset serving a competing hospital. A PSA would be effectuated, but just for a subset of the professional services or providers. All related administrative costs will be carved out as well and reimbursed by the organization accordingly.
5. *Hybrid Arrangements*. Countless variations of the models above are possible, allowing the prospective partners to mix and match the desired qualities of each within their PSA. For example, the organization could employ or contract with physicians, and the practice entity could spin-off into a jointly-owned MSO/ISO.

Of the five structures listed, the prevailing models in today’s markets are the global payment PSA, the traditional PSA, and the carve-out PSA. The practice management arrangement may be a viable option for some practices, although it is selected less frequently than the other models. Hybrid scenarios abound as the deal-making process and various negotiations unfold, particularly as we move into second generation agreements.

## GLOBAL PAYMENT MODEL PSA

The global payment PSA model most closely resembles the practice as it was before alignment. Specifically, all physicians and staff remain employees of the practice, and management of the practice maintains its pre-PSA structure. The only difference is that the practice is contracted to provide professional services to the hospital or other entity, and that entity now owns the revenue stream. Under the self-employed status, the physicians receive no employee benefits (e.g., health insurance, malpractice coverage, etc.) from the hospital, with the practice continuing to provide them. The hospital is no different from any other outsourced contractor in that the relationship falls under the IRS 1099 tax arrangement.

In these agreements, typically the practice receives payment for the physicians' professional services, calculated based on productivity, as defined by wRVUs.<sup>1</sup> This methodology is the most popular and easy to construct model for determining compensation. However, as the reimbursement landscape continues to shift toward value-based care and performance-based fees, the compensation landscape is moving in tandem. As such, some hybrid compensation models are now in use within the global payment PSA model based on something other than solely production. For example, some agreements are now placing a portion of total compensation at risk for value-based tenets.

In the global payment PSA model, the revenue stream and the responsibility for it shift to the hospital or other entity contracting the physicians for professional services. This entity, as opposed to the practice, is now responsible for the payer contract negotiations, billings, collections, and the entire revenue cycle.<sup>2</sup> In turn, the practice receives compensation for the services provided based on defined terms and conditions. Primarily, these terms are established based on the professional services that the physicians perform and are mostly productivity based (using wRVUs), along with some non-productivity-based incentives (see below for further discussion of the compensation matrix).

The global payment PSA is a "full" alignment model, yet it stops significantly short of W-2 employment. Under the global payment PSA model, in addition to wRVU-based compensation for the services provided, the practice receives remuneration for its overhead, often on a budgeted dollar basis. That budgeted amount may have some consideration for variable expenses (i.e., expenses that vary with revenue), usually based on a rate per wRVU. Nevertheless, since the vast majority of practice overhead is a fixed (or mostly fixed) cost, the global payment PSA reimburses the practice for the majority of its overhead on a fixed or budgeted basis.

Alternately, the practice can be reimbursed using a total rate per RVU. Although some early global payment PSA models were structured in this manner, in recent years most arrangements are based on a budgeted overhead reimbursement basis as well as some limited

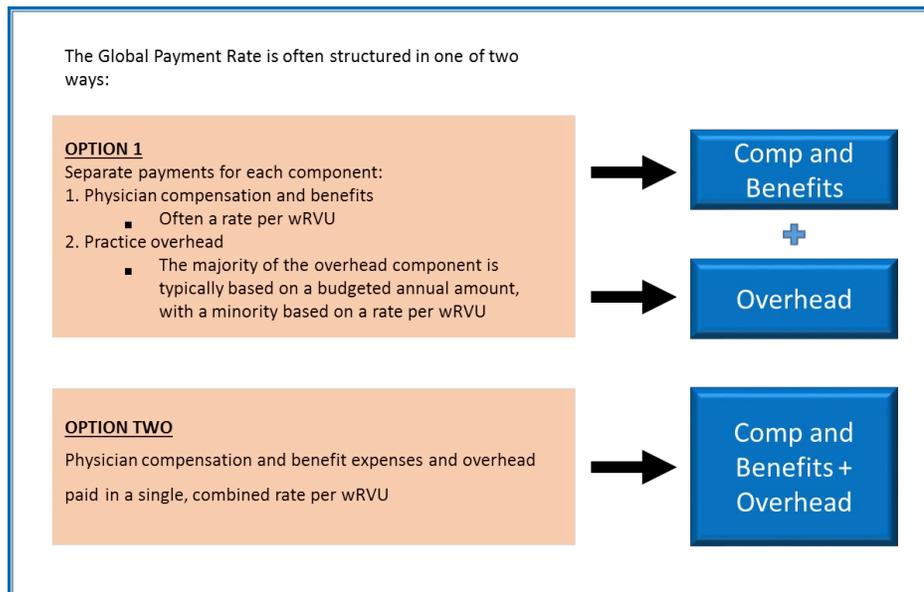
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<sup>1</sup> A relative value unit (RVU) describes a unit of work (i.e., productivity) for each CPT™ code within that overall organized system of structure. For each CPT™ code, each of the three components of services rendered is assigned an RVU value and then summed to create the total RVU for that specific code. Thus, the sum of the work-only component (i.e., wRVU), the practice expense RVU, and the professional liability insurance RVU equals the total RVU value for each CPT™ code. To derive reimbursement for Medicare purposes, the total RVU is multiplied by the then-current assigned conversion factor.

<sup>2</sup> While the billing and collection functions are the responsibility of the hospital, in some cases, such as the global payment PSA, the hospital may choose to outsource these functions to the practice as a third-party billing agent.

amount of variable expenses paid on a rate per wRVU (see above). Figure 1, below, illustrates the potential payment methods to the practice under a typical global payment PSA model, with Option 1 currently the most prevalent methodology of the two.

FIGURE 1. PAYMENT ALTERNATIVES WITHIN THE GLOBAL PAYMENT MODEL



Other notable facets of the global payment PSA are that post-alignment, the hospital will:

- Own the accounts receivable.
- Establish the fee structure.
- Contract with payers.

The ownership and assumption of the ancillaries are negotiable terms in the global payment PSA structure. However, usually, the hospital takes responsibility for delivering the ancillary services and attaining the subsequent revenue. Though the practice may either retain the ownership of the assets that support the ancillaries and lease them to the hospital or sell them outright to the hospital, the stream of income and resulting accounts receivable shifts to the hospital. This scenario is similar to employment and substantiates our references to this model as a form of employment lite.

To drill down further on the integral components of the global payment PSA, Figure 2 summarizes the differentiation of ownership, assignment responsibilities, etc.

FIGURE 2. RESPONSIBILITIES WITHIN THE GLOBAL PAYMENT MODEL

Global Payment Model		
	Practice	Hospital
Employment of Physicians	X	
Employment of Staff	X	
Real Estate Ownership	*	*
Ownership of Ancillary Equipment and Staff	*	*
Payer Contracting		X
Tax ID Used		X
Reimbursement for Practice Overhead		X
Ongoing Management of Practice	X	X (through Management Committee)
Billing/Collections Functions	*	*
Recruitment of Physicians	X	
Capital Expenditures	Defer to Management Committee	Defer to Management Committee

\*Depends on negotiated structure

In summary, the global payment PSA requires ample objectivity and trust between the hospital and the physician group. However, the global payment PSA is quite logical and offers a prospective segue toward an ultimate agreement. Sometimes, the health system's goal is for the practice to be aligned fully through employment. However, it may take time to reach employment; thus, the global payment PSA is a positive means for initiating a working relationship between the two parties. Conversely, many global payment PSAs renew and extend with neither party expressing interest in converting to another model (i.e., employment or even the traditional PSA). Indeed, the global payment PSA can be a useful and enduring model.

## PRACTICE MANAGEMENT ARRANGEMENT

The practice management arrangement (PMA) model is structured whereby the physicians and potentially the advanced practice providers (APPs) are employed by the hospital, which makes it unique to the other models. The infrastructure of the practice entity remains independent, and the management and administrative structure of the practice continues to support the now-employed providers. Thus, the physicians and practice continue to retain an element of independence and autonomy in preserving their management structure. The key in this model is that by maintaining the practice infrastructure, it is easier for the practice to revert to a private practice setting or even align with another health system post-termination, assuming the restrictive covenant and/or non-compete terms allow for it. Therefore, it is important to know the likelihood that this scenario could not work out long-term before engaging, as this will drive negotiations.

One main concern physicians have regarding alignment with a hospital is that they are typically ill-equipped to manage private practices. Thus, the practice infrastructure of management and operations may be more efficient as well as better operated and managed when maintained independently, as compared to if it were acquired and subsequently controlled hospital. Additionally, this arrangement allows for a smoother transition into a PSA. At some point, this infrastructure could still be transferred to the hospital.

Under the PMA, the physicians operate as managers of the practice, which now functions as a back-office support structure, as opposed to a functional and comprehensive clinical practice, providing administrative services, space, equipment, and support staff. The hospital contracts with the practice entity for these services and pays a fair market value (FMV) management fee.<sup>3</sup> The compensation structure for the employed physicians is no different than if they were employed and did not provide the management services. In other words, the compensation to the physicians and APPs is consistent with any other W-2 employment arrangement. As such, it can include a base salary, both productivity and non-productivity-based incentives, and other forms of guaranteed and at-risk compensation.

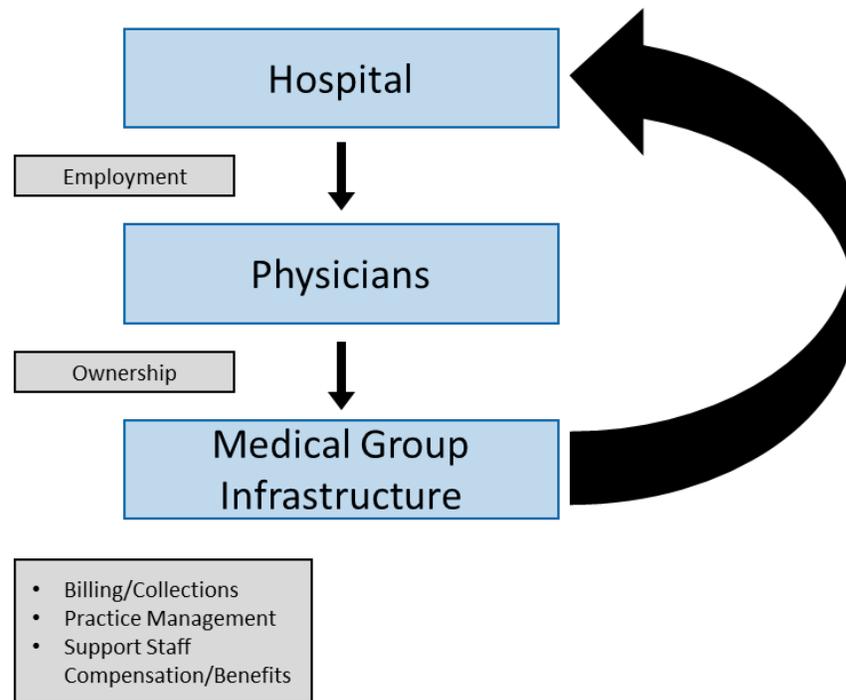
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<sup>3</sup> The negotiations relative to the management fee can be sensitive given the fact that the physicians are now negotiating with their employer. Hence, it may be best to enlist the services of an independent third-party expert to complete same.

The advantage of the PMA is that the practice can be easily transferred to full ownership by the hospital, or because by retaining the infrastructure, the providers could also revert to a private setting, post-transaction. Reverting is typically not preferred, nor the intent when entering the transaction, but the provision allows for a check and balance in the alignment process. Although the perception of this caveat may be too high a negative actor for the hospital, a lack of flexibility may also be the single greatest obstacle in getting the physicians to agree to complete the transaction in the first place. That is, the physicians-practice owners may lack trust or confidence in the hospital to manage their practice-operations efficiency. Once these fears are mitigated and trust gained through the PMA, the PSA structure could easily convert to a standard employment model, whereby the practice entity is dissolved, and all staff absorbed (employed) directly by the hospital. As an alternative, this structure could evolve to allow for a jointly owned management entity between the physicians and the hospital. Combining ownership in the management structure is more complicated and requires much more scrutiny and analysis to make sure that the structure is both fair and reasonable but also legally compliant and consistent with all applicable federal and state regulations. Nonetheless, this level of flexibility exists within the PMA.

So why even consider a PMA within the spectrum of employment lite options? The answer to this question should be rather obvious. That is, the physicians may already have a management services organization (MSO), or they may believe that their management structure is more efficient and better run than it could be by the hospital with whom they are aligning. Furthermore, the confidence that the transaction will stand the test of time, even moving into a “second generation” model, may be lacking at the outset of the working relationship. Thus, the physicians, while accepting the premise of becoming employed themselves, may not want to give up the operations and management oversight. With this noted, most second generation transactions have moved away from the PMA if this is the initial alignment relationship. However, undoubtedly, the PMA could continue beyond an initial term and be extremely functional. Figure 3 illustrates the PMA model.

FIGURE 3. PRACTICE MANAGEMENT ARRANGEMENT



### TRADITIONAL MODEL PSA

The traditional model PSA is arguably the most common PSA structure and is closest to full employment in the way the practice functions. Under this model, the hospital or other entity undertakes all responsibilities for practice management, including hiring and supervision of support staff (e.g., clerical staff, practice administrators, non-physician clinical employees), assumption of operational and administrative duties, leasing or purchase of practice assets and locations, and any other functions necessary to support the physicians’ defined scope within the PSA. The practice entity remains intact, though somewhat hollowed, and the physicians remain employees of that practice, contracting with the organization for professional services. APPs may or may not stay employees of the practice, depending upon the structure of the practice and goals of the organizations.

Again, from an operational perspective, the ultimate result is a structure that looks and feels like employment in that the practice transitions its “ownership” of all management and operations to the hospital and is no longer directly accountable for these functions. The practice is relieved of all day-to-day operational oversight, including the risk of operating from a financial/economic standpoint. This change is the largest differentiating point between this and

the other PSA models previously discussed. Some physicians see this shift as a positive, as they feel relieved to have handed over responsibility for the operations of their practice to a hospital partner. However, other physicians interpret this transition as a loss of control, which makes the model less desirable to them. Ultimately, in this model, the “practice” stays intact, but only from the viewpoint of the physicians and perhaps the non-physician providers, who may also remain in the existing practice entity. Similar to the global payment PSA, under the traditional PSA, the hospital controls the payer contracts, including the negotiation of them, and bills for all professional charges going forward, and thus owns the accounts receivable. All other areas of the practice transition to the property/control of the hospital, while the practice stays intact from the standpoint of the physician ownership of that professional entity. The only remaining component of what was the previous practice is its professional members, i.e., the physicians. The key to this model is that the hospital has responsibility for ongoing management of the practice, and the physicians do not.

Figure 4 identifies the differing scope of responsibilities of the health system and the medical group under the traditional PSA, illustrating that the practice may be able to retain the ancillary services if so desired, which may be a preferable option for some specialties. Ancillary services are an essential component of these PSA affiliations. Like employment where the hospital implicitly acquires them, along with the entire practice entity, the PSA models consider the possibility of a similar scenario. However, a significant distinction between these PSA models and full (W-2) employment is that the practice does not have to sell its ancillaries. However, the PSA model itself often drives this discussion, as ancillaries are more likely to be acquired by the hospital in a traditional PSA than the other PSA models.

FIGURE 4. RESPONSIBILITIES WITHIN THE TRADITIONAL PSA

Traditional PSA Model		
	Practice	Hospital
Employment of Physicians	X	
Employment of Staff		X
Real Estate Ownership	*	*
Ownership of Ancillary Equipment	*	*
Payer Contracting		X
Tax ID Used		X
Bears Cost of Practice Support Overhead		X
Ongoing Management of Practice		X
Billing/Collections Functions		X
Recruitment of Physicians	X	
Capital Expenditures		Through Management Committee

\*Depends on negotiated structure

## CARVE-OUT PSAs

A variant of the models above that has grown in popularity in recent years is the carve-out PSA. This PSA involves a subset of the practice aligning with a strategic partner versus the entire practice engaging in a PSA. One prime example is when a single specialty within a private multi-specialty practice aligns with a hospital. With its evolution, we now see this model occurring for even subspecialized physicians within a single specialty (for example, only the hand surgeons within an orthopedic practice). While the carve-out can take the form of any of the previously-discussed PSAs, the usual structure is a global payment PSA, with the overhead reimbursement limited to the direct overhead and some limited allocated overhead for the attributable physicians within the PSA.

This model began in earnest for cardiology after the significant cuts in their reimbursement for echo and nuclear studies in 2009. At that time, many cardiologists started looking for stability, but they were reticent to leave their private practice model and become employed. As a result, numerous practices approached hospitals about carving out their cardiologists and forming a

PSA with only those physicians from within the practice, thus launching the popularity of the carve-out PSA.

In more recent years, this option has been used to address any number of nuances that require a section of the practice to be contracted separately from the rest of the practice. Additionally, a recent example is carve-out PSAs whereby the providers have the option of participating and supporting the PSA. For example, an organization may only need 0.2 FTEs per week to support their services and contract with a large practice to support those needs. A subset of a provider may agree to meet the needs of that organization, with the goal to increase their market presence or productivity.

### ADDITIONAL SERVICES WRAPAROUNDS

Regardless of the PSA model pursued, there are opportunities available to practice physicians and their hospital partner above and beyond the baseline scope of services defined in the PSA. These “wraparound” structures are typically wrapped around the core PSA model, and include the following:

- Clinical co-management
- Shared cost savings initiatives
- Administrative duties
- Non-physician provider supervisory duties
- Teaching functions
- Research
- Medical directorships
- Call responsibilities

An additional wraparound that is a part of some PSA relationships is an incentive for quality. This component is growing in popularity as the overall healthcare reimbursement paradigm shifts to a more significant focus on quality. In its most limited form, this structure involves an incentive payment to physicians for merely reporting on their actual cost, quality, and/or outcome data. In its most robust form, the model included hospitals providing at-risk compensation to physicians for demonstrating simultaneous achievement of both high-quality and cost-efficient care. Other organizations have shared savings that are achieved based on the improvement of quality scores and, therefore, the reduction of penalties from CMS. Quality incentives are an important part of PSA relationships, and both their prevalence and level of economic impact within individual PSAs is increasing. It is not uncommon to see quality as a component of total PSA compensation, either in addition to or instead of production-based

compensation. As opposed to having quality outlined in a separate but corollary wraparound agreement, it is more often becoming a central component of the PSA model itself, impacting the funds that flow to the physicians more than ever before.

Wraparound scenarios offer excellent opportunities for some additional forms of alignment, although in limited or moderate forms, and are complementary to the core employment lite/PSA structure. They do come at an additional price to the hospital in that the physicians can be compensated for these services legitimately, assuming there is an appropriate definition of duties and responsibilities and documentation of their work. However, recognizing that performing these duties requires additional time, physicians must be willing to forgo clinical responsibilities to perform these duties. This work also comes at a cost for the physicians. It is noteworthy that while additional compensation is fair and legitimate, total compensation must still be within fair market value.

## PSA STRUCTURE COMPARISON

A comparison of the four key PSA models discussed above is in Exhibit III. This chart depicts the standard terms of PSA models and how they differ between the global payment PSA, the practice management arrangement (PMA), the traditional PSA, and the carve-out PSA.

## REIMBURSEMENT TRENDS

Value-based care is a real and significant trend in healthcare delivery, which is most evidenced by the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) introduced by CMS in 2017. Though some government programs have slowed due to administration changes, the need to address healthcare costs is a well-publicized and bipartisan issue that will remain a focus for the industry regardless of mandated programs. Commercial payers have continued to push for these changes and are implementing more value-based contracts across the country.

The value-based reimbursement models being adopted vary widely; however, the models that have grown in prevalence recently include shared savings, shared losses, and bundled payments. Shared savings programs can be structured in different ways. The basic concept is that if a payer spends less on a procedure than the expected level, the provider is entitled to a share of that savings. Shared losses are essentially the same concept as shared savings, except that the provider would owe the excess amount spent by the hospital on a standard procedure. Bundled payments offer a single payment for an episode of care, encompassing all

services from the admittance of the patient to post-discharge periods and including allowances for abnormalities such as complications.

These new payment changes will affect how hospitals and practices interact, pushing physicians to seek alignment with hospitals to ensure they can take advantage of some of these models, including those that require ACO participation. Meanwhile, hospitals are looking to employ or integrate with physician groups that have historically demonstrated positive outcomes and, thus, could take advantage of their quality initiatives. In any scenario, the two constituencies are being incented to work together now more than ever to capitalize on the value-based incentives being offered both by Medicare and private insurance payers.

All of these changes to reimbursement are serving to drive physicians and hospitals to work more closely together. Many structures exist to accommodate such relationships, with the PSA model being just one viable option.

## LEGAL CHALLENGES APPLY

Many of the same legal considerations still apply when considering PSA models versus a full employment arrangement. Hospitals and practices need to remain cautious and aware of these issues when entering an agreement to ensure they stay within the confines of the law.

The issues of fair market value and commercially reasonable rates of compensation are present within any of the PSA models. However, this is no different from employment or another financial relationship between a hospital/health system and a physician. Wraparound agreements are likewise subject to FMV/commercially reasonable rates of compensation. We recommend that once the compensation structure is designed, it should be reviewed; ultimately, an independent valuation expert should render a formal opinion as to the veracity of the compensation structure and amount.

Hospitals must also certify that the PSA agreement does not break Stark Law through referrals of patients. While fair market value assessments play a significant role in ensuring this, there are other nuances of the law that must be observed. In addition to Stark Law, hospitals are also beholden to federal anti-kickback statutes. PSAs must be arranged in such a way as to eliminate kickbacks from referrals of Medicare and Medicaid patients to the hospital. Although these two points cover most federal regulatory issues, the hospital still needs to be educated on their state laws, which can sometimes impose even stricter restrictions on the agreement.

After serious consideration of these matters and with the completion of appropriate due diligence, the compliance and legal challenges, while still present, should be mitigated significantly. With this in mind, there are no legal restrictions on the PSA models, however they must be structured to comply with the regulations in various relevant areas of the working relationship, especially the economic arrangements between the hospital and the physician group.

Finally, many of these structures are relatively new and not tested to the fullest degree. It is critical to consult with an experienced healthcare attorney before entering into any arrangement discussed in this paper. Moreover, hospitals should consider reviewing the PSA agreement and fulfillment periodically to ensure compliance with all federal and state healthcare laws.

## OVERALL BENEFITS OF EMPLOYMENT LITE MODELS

As with all things, there are advantages and disadvantages to the PSA model. In most cases, the “cons,” which include such matters as less stability than employment, or the inclusion of a non-compete or exclusivity provision, are seldom untenable and, thus, can be addressed through productive discussions and negotiations between the parties.

The benefits of the PSA include the following:

- Physicians maintain their independence from the hospital by remaining either an employee of the practice or controlling their management infrastructure, which would enable them to go back into private practice smoothly.
- While these models are more complex than direct employment, their structures offer high flexibility, and some physicians often prefer (at least initially) going into such an alignment arrangement.
- Under some PSA models, specifically the global payment and traditional PSAs, and their subsequent carve-outs, physicians can keep their existing benefits plans in place.
- The support staff may be employed by the hospital but remain with the practice while typically enjoying the perks of being employed by a larger organization (i.e., better benefits, job security, etc.).
- The structures are similar to employment, yet there are distinct differences that are often prevailing in preferences for the physicians.
- The PSA structures can be viable segues to full employment, as many physicians need time to make certain that the hospital partner is the “right” long-term affiliate.

- The PSA structures can be viable segues to participation in the hospital's CIN or ACO.
- While perhaps slightly less stable than employment, the PSA models offer a high level of stability for the hospital and physician relationship going forward.
- Hospitals can support complex reimbursement trends better due to more robust infrastructure systems (i.e., MIPS requirements).
- These models offer opportunities to increase revenue (within legal and ethical bounds) as well as to control costs.
- The PSA models present opportunities for physicians and hospitals to expand services together without being fully aligned (i.e., employment).
- Wraparound agreements (i.e., a clinical co-management arrangement and/or medical directorship) are easily structured within the PSA models and usually are a viable complement to them.
- The ability to unwind and disengage from the relationship is greater under the PSA models than traditional employment, particularly if there is no post-termination non-compete.
- While the ability to unwind exists, there are usually agreements that require high levels of commitment and inhibiting factors regarding the overall capacity for the practice to partner with someone else (e.g., exclusivity and non-compete terms are typical traits of the PSA models).
- The ability to expand the elements of clinical integration exists within the PSA models. Like employment, clinical integration is clearly possible, and the strategies prior to CINs/ACOs can easily be implemented in the PSA models.
- By nature, the traditional and global payment PSA models provide the physicians with a level of independence and autonomy that employment cannot offer.
- The carve-out option allows all parties to hone in on the areas of greatest need, either for the practice or the hospital, or both.
- The carve-out option also extends the opportunity to partner under a fully integrated structure but on a more limited basis.
- Although often not as favorable as full employment from the hospital or health system standpoint, the PSA models provide full integration with the practice.
- The parties often share the same electronic medical record (EMR) system or have access via interfaces/portals, which facilitates care coordination, data sharing, communication, and overall care management.
- From the hospital system, often the PSA models are more attractive because they reduce the usual economic and financial risk of owning and managing a medical practice, which is especially applicable to the global payment and practice management arrangement PSA models.

- A management committee should be structured to develop joint strategies and other day-to-day operative initiatives, such as budgets and areas of opportunity for growth and expansion. Thus, the management committee within the PSA contract provides many of the governance and decision-making processes that should exist, regardless of the alignment model.
- While the four PSA models described are the primary structures, hybrid variations can be created to accommodate the specific needs of both the hospital and the practice.
- Private practices can continue driving clinical decision-making and can better meet the expectations of value-based care than full employed providers.
- The PSA models will not preclude the establishment of fully-aligned models and other important structures, such as patient-centered medical homes and ultimately, ACOs/CINs.
- Both the hospital and the private group are better prepared and equipped to respond to the “accountable care era” in a manner that does not compromise their current operations/structure.

Exhibit III, *PSA Model Comparison*, can serve as a useful tool for the physician practice and the hospital to determine if the PSA is an appropriate strategy for the parties involved, and if it is the best fit for current and future planning, strategic goals (i.e., succession planning), and the unique market environment in which they exist. The global payment PSA works well for physicians who are interested in maintaining a clinical practice and continuing to manage a business. This arrangement includes retaining control over staff, managing overhead, and supervising other daily operations relating to their office.

Some physicians only want to be responsible for the clinical — not the business — aspects of medicine. Those physicians fare better with the traditional PSA because it eliminates the responsibility to manage the business side of the practice. In this model, the health system partner employs the staff, and the hospital manages the overhead. Physicians in this scenario can focus solely on productivity.

The carve-out PSA option allows only those physicians and/or only those sites/services that are necessary and/or desired to be a part of the PSA. The parties realize the numerous benefits of greater integration without experiencing the full breadth of a comprehensive transition process.

Finally, by retaining its management infrastructure, the practice management arrangement (PMA) allows the practice to achieve its goals of flexibility in the event it elects to revert to a

private practice setting if the employment arrangement does not prove satisfactory. Also, the employment of the physicians and other providers is an effective alignment strategy, providing opportunities for improved relations and even economic and performance outcomes.

## IS EMPLOYMENT LITE FOR YOU?

Figure 5, *Employment Lite Checklist*, summarizes key items to evaluate if your practice or hospital is considering pursuing one of these models, and can assist in predicting which alignment model would be best for your situation. These questions apply to a hospital/health system and a qualified medical group.

FIGURE 5. EMPLOYMENT LITE CHECKLIST

QUESTION	ANSWER
1. What does the practice prefer regarding overall structure relative to its alignment? For example, does the practice believe that the hospital's management structure is lacking and, further, are there questions in the minds of the practice about the sustainability of the hospital management structure? Currently, does the hospital provide adequate support services for their aligned practices?	
2. Is there a strong preference among the parties (i.e., both the practice and the hospital/health system) for the staff to be employees?	
3. What is the gestalt of the parties relative to ancillary services? What are the applicable state (and federal) legal requirements and parameters surrounding the issue? Is it essential for the hospital/health system to own the ancillary services going forward?	
4. How are leadership and governance addressed? What are the voting rights and reserved powers the health system may require? What will be the effect of ethical and religious directives, if applicable?	
5. What value-based criteria are to be considered, and how will they affect the PSA model going forward? Will a portion of the compensation plan include consideration of such non-productivity-based (i.e., value-based) criteria?	
6. Is compensation comparable under both PSA and	

employment? Are fair market value/commercially reasonable rates under consideration, regardless of the structure? Has an independent valuation expert provided an opinion?	
7. What assurances does the physician group have that the hospital/health system will allow a level of independence and governance, particularly if the structure is the practice management arrangement (PMA) or traditional PSA model?	
8. What is the term of the agreement? More importantly, what are the rights for early termination (with or without cause)?	
9. How much security, both financial and otherwise, will the hospital/health system provide to the practice? What guarantees of income may exist?	
10. What leadership duties and responsibilities will be assigned to the physicians? These may include medical directorships as well as non-clinical leadership positions.	
11. What service line responsibilities and assignments, if any, will the physicians have?	
12. Does the PSA include any wraparounds? For example, are there any clinical co-management or service line management responsibilities? What about medical directorships? Are these enveloped within the PSA or subject to a separate agreement?	
13. Have the strategic, relational, economic, and functional advantages or disadvantages been articulated between the hospital/health system and the practice? Does the employment lite structure allow for full alignment as well as a high level of partnership?	
14. What is the status of the staff and their security, as well as compensation, assuming the traditional PSA is the model of choice? Will there be a guarantee of employment for a period of time, post-transaction?	
15. What are the restrictive covenant/non-compete terms and conditions? Are they different than what an employment model entails?	
16. What are the terms of the employment lite agreement in the context of a changing reimbursement paradigm? For example, if a shift from productivity- to value-based	

reimbursement occurs, would the increase trigger an automatic change in the compensation structure from productivity to value?	
17. Under the global payment PSA, how is the overhead reimbursed? Is the amount a budgeted total? A fixed amount that is only adjusted upon mutual agreement through a governance committee? Or, is it a combination of a fixed budgeted total to be reimbursed and certain variable expenses tied to wRVUs?	
18. Is the employment lite model a precursor to employment? Is this matter specified in the definitive agreements?	

These questions and your answers will address many, if not all, of the key terms and conditions of an employment lite agreement. The information you gather will enable you to summarize and analyze your position before consummating the employment lite contract.

## CASE STUDIES

The aspects of the professional services agreement described above are general in nature. The following sections address specifics to past Coker clients, laying the groundwork, outlining the actions, and reporting on the progress of the various arrangements after their implementation.

### CASE STUDY #1. GLOBAL PAYMENT PSA

A 61-physician, multi-specialty practice in the Midwest was considering ways to align with a local health system. Recognizing that they did not have any experience with anything other than limited forms of alignment with this system in the past, they desired an alignment structure that would accommodate a single service line, at least initially, to establish trust between the organizations, and create an alignment foundation that they could build on in the future. The practice recognized a relative strength within their orthopedics department and initially wanted to develop an alignment structure with this department only. However, the practice realized that from a strategic perspective they needed first to increase the size of their orthopedic provider base to create the leverage they desired in their local market. As a result, the practice acquired a single-specialty orthopedic practice in their primary service area. The practice obtained the smaller group not only because of their desire to expand but also because the smaller group was a solid cultural fit and was in agreement with the practice's desire to align more fully with the local health system. With the addition of the single specialty

orthopedics group, the practice increased their orthopedist provider base to 20 physicians across a range of subspecialties (hand, foot and ankle, sports medicine, etc.). Then the practice approached one of the local hospitals regarding potential alignment, exclusive to this service line; that is, they requested a carve-out PSA, with a global payment PSA structure. The practice came from a position of strength, as they had the majority of orthopedic providers within the community unified, and they were negotiating on behalf of the entire group. This position allowed them to have influence over the alignment structure as well as the terms and conditions of the transaction. Also, because the local market included more than one health system, the practice had the leverage to approach another health system if their preferred partner was unwilling to meet their desired terms. Ultimately, the multispecialty group carved out their orthopedic service line under a PSA while the remainder of the group remained private. The orthopedists are currently aligned with the health system under a global payment PSA at a specified rate per wRVU. The table below defines the payment schedule.

TABLE 1. PAYMENT SCHEDULE

Total Unit wRVUs	Global Fee/wRVU		
	Year 1	Year 2	Year 3
<b>Tier One: 0-144,000 wRVUs</b>	\$96.00	\$97.92	\$99.88
<b>Tier Two: 144,001-155,000 wRVUs</b>	\$98.00	\$99.96	\$101.96
<b>Tier Three: 155,001 wRVUs and Above</b>	\$100.00	\$102.00	\$104.04

In this transaction, all wRVUs produced up to 144,000 (an aggregated total for the group) are compensated at \$96. After this Tier One production threshold is exceeded, the excess wRVUs up to 155,000 are compensated at \$98. Finally, any wRVUs above 155,000 are compensated at \$100. The payment structure is incremental rather than retroactive, meaning that the wRVUs in each tier are compensated at that individual tier rate. For example, if 151,000 wRVUs are produced, 144,000 are compensated at \$96, and 7,000<sup>4</sup> are compensated at \$98; all 151,000 are not compensated at the higher rate (e.g., \$98). Also within the practice's compensation model is an escalator for years 2 and 3 of the agreement, where each tier receives a 2% increase in compensation.

This global payment PSA structure falls into option one (see the previous section for global payment compensation alternatives), where the compensation rate per wRVU includes consideration of both the practice's overhead expenses as well as physician compensation and benefits. Also, because this PSA included a carve-out for a single department within the larger

<sup>4</sup> 151,000 minus 144,000

practice, the overhead expenses that were effectively calibrated in the determination of the global payment PSA rate were specific to orthopedics-only expenses, rather than the entire overhead rate of the practice. This action is necessary for compliance purposes and also makes logical business sense.

As a result of this transaction, the practice has solidified its relationship with one of the local health systems for the foreseeable future. Further, the potential for closer alignment exists across additional specialties in the near term. This practice's experience demonstrates the benefits of foresight. By aligning first with another orthopedic group and then with the hospital, the practice stabilized their orthopedic service line and strengthened their provider base. This groundwork will support their position in future negotiations with the hospital or its competitors, much as it did in its initial negotiations.

#### CASE STUDY #2. PRACTICE MANAGEMENT ARRANGEMENT

A 49-provider multi-specialty practice in a large metropolitan area in the Southeast was considering aligning with a health system as a way to prepare for the shift to accountable care. The practice was well respected within their primary and secondary service areas, had high patient satisfaction and low employee turnover, and was fiscally sound. The practice had no actual need to align with a partner (i.e., there were no financial challenges and no real operational risks) but felt that alignment was an important consideration as they prepared for coming changes in healthcare.

As a result of the size of their community, the practice had several options relative to potential partners, including two major health systems, each with a number of inpatient facilities throughout the region, and a smaller, independent, stand-alone hospital. While this situation is a "good problem" to have because it results in options to consider and creates leverage for the practice, deciding which hospital to partner with was the single most difficult decision for the practice throughout their due diligence process.

One difficulty in the decision-making process was the variety of alignment models that were proposed by the various potential partners. One of the first challenges for the practice was understanding the proposed models and the strengths and weaknesses of each. The practice recognized that they wanted to retain some level of autonomy, so the acquisition of the practice and employment of all staff and physicians was not seen as viable. They also knew they wanted a closer relationship than a joint venture would afford, so they limited their consideration to the traditional PSA and the practice management arrangement.

One of the two larger health systems in the community proposed the practice management arrangement. Under this system's model, the physicians would become employed through a wholly-owned subsidiary of the health system. This employment would allow the practice to remain separate from the system's existing physician network. The practice was unwilling to join the system's more extensive, existing physician network as they felt it would eliminate the group mentality they had worked hard to create among their providers. The health system proposed a compensation model where the physicians received the greater of their guaranteed compensation equal to prior year actual compensation or their productivity-based compensation based on a practice-wide conversion factor, which would be multiplied by the actual number of wRVUs produced. Under this model, the health system would not acquire the tangible assets of the practice but would execute a management services agreement with the practice under which they would pay a fair market value fee for all services provided by the practice. Such services would encompass compensation and benefits for practice staff, billing and collection services, equipment, clinical and support space, and administrative management services. The health system believed that this model would create a platform for clinical integration between the parties but also helped to ensure the existing practice structure remained in existence and continued to improve its operations.

The practice ultimately decided to pursue the practice management arrangement and, as a result, chose to align with the health system that had initially offered it, because they were not ready to completely divest of their staff and operating infrastructure as would be required under the traditional PSA that had been proposed by the other system. This transaction has now been ineffective for its entire initial term and is in the process of renegotiations for a second term. The health system and practice continue to be pleased with the level of clinical integration that has been possible under this model, and they are busy working toward the development of their mutual ACO entity.

### CASE STUDY #3. TRADITIONAL PSA

An eight-physician single specialty cardiology practice in the Northwest was continuing to feel the pressure of declining reimbursement, particularly for their diagnostic ancillaries after the changes in CMS reimbursement for these services. Additionally, the practice was having difficulty managing their expenses. At a time when reimbursement was declining, their overhead seemed to be steadily increasing, not only as a percent of revenue, which would be expected, but also in "real dollar" terms. For this practice, the overall business operations were becoming more burdensome by the day and were requiring additional time from the physicians that they needed to be spending increasing their patient throughput to help ensure the practice's ongoing financial solvency. As a result, the practice approached the local hospital (in

this area, there was only one main hospital within a 30-mile radius of the practice) regarding potential alignment. Unfortunately, like many cardiology groups, this practice needed to align with the hospital because of the fear that their increasing economic challenges would soon become insurmountable.

The local hospital was quite willing to align with the practice, as they recognized this transaction would likely create greater stability within their cardiology service line, something that the hospital had been lacking. At that time, the hospital employed three cardiologists and wanted to expand its provider base to ensure adequate coverage. For example, the hospital only employed one interventional physician, which was creating difficulties in providing consistent coverage for interventional services. The hospital and practice agreed to pursue a traditional PSA, where the physicians would remain employees of the practice, but the staff, overhead expenses, and management functions of the practice would transition to the hospital. Further, the hospital purchased all existing ancillary assets.

The hospital developed a single-tier productivity-based model where all physicians received compensation at the highest rate then offered by the hospital to its employed physicians to ensure the relationship between the existing employed physicians and those newly contracted was consistent and amicable. For the practice physicians, this shift resulted in a compensation increase of 10 to 15% over the prior year. Ultimately, it helped bring the physicians back to their 2008 historical compensation levels, which was reflective of their consistent levels of compensation before the cuts in CMS reimbursement for cardiology services. The physicians were elated to receive this increase in compensation and to be relieved of the practice management responsibilities, which had increased significantly over the past several years.

Although the physicians and hospital were pleased with the traditional PSA, they have recently transitioned their relationship into full employment, including an acquisition of the practice and employment of the physicians. The physicians have now built trust with the hospital and consider this transition desirable. This example demonstrates the ability of a PSA model to (a) meet immediate needs, (b) allow physicians to remain in private practice yet still aligned with a hospital, and (c) serve as a natural segue to employment.

These three case studies demonstrate the flexibility of PSA arrangements and some of the solutions that they offer when adopted.

#### CASE STUDY #4. PSA BETWEEN TWO PRACTICES

A mid-sized (15-physician) multispecialty practice in the Southeast with majority primary care, located in a rural community outside a larger metropolis, was seeking to expand its service offerings to include orthopedic services to meet the needs of the community. Due to the proximity to the larger city, most patients received their orthopedic care at a reputable practice located in that area, though many struggled with the distance and ensuring the receipt of efficient care. The practice sought a partnership with these physicians to meet these needs.

Not understanding their options for such a formalized partnership, the practice enlisted assistance from a consulting firm to vet alternatives. The practice noted that they would like to keep the revenue from their ancillaries and continue to build the local market awareness of their services, as well as ensure that primary care remained within their community. Additionally, the practice believed that providing care in that location would be best for its patients and develop a more efficient system, both for the patients and the providers. The practice considered hiring its own orthopedic surgeon; however, the providers were concerned that the provider would have too much competition with the established practice in the neighboring city.

After discussing options, the consulting firm recommended pursuing a carve-out PSA with a single physician from the established orthopedic practice to provide services one day a week in their clinic. The parties met to discuss the potential here, and both seemed amenable to the idea. A newer physician with lower volumes than the other more established providers realized this would be an effective way to draw patients to his practice while ensuring consistent care. The practice agreed that this would keep patients in their community for care and best meet the needs of its patients while continuing to draw revenue from the ancillary procedures ordered within the facility.

The carve-out PSA was established as a traditional PSA structure for the single physician. The practice provided all necessary overhead and support and contracted for the professional services only. The physician received compensation based on a wRVU-basis and completed recommended procedures within the ASC owned by his practice.

Resultantly, the physician grew his volumes and was able to meet with patients near to their home, decreasing post-operative costs and readmissions. The practice realized increased ancillary volumes and improved patient satisfaction. Finally, the patients expressed appreciation for the scenario and continued to drive growth for both business entities.

## SUMMARY

The shifts in the healthcare industry have created widespread changes throughout all components of the business. As a result, practices and healthcare organizations are seeking ways to improve their alignments to weather the storm together. PSAs have offered a unique way to achieve these outcomes while still capitalizing on the benefits of maintaining a private practice structure. PSAs resemble employment at their core, hence the term employment lite. They make an excellent vehicle for alignment for those that are somewhat wary of entering immediately into full employment. As such, these models have grown increasingly more prominent over the past ten years. While these are still in the minority as compared to strict employment models, all parties are beginning to be more amenable to considering alternatives to these traditional functions.

As healthcare continues to shift toward value, modern alignment structures will continue to rise in popularity, with many serving as the foundation for clinical integration. PSAs will remain as a key alternative to employment under this paradigm, and with nuanced and varied benefits, it should stay at the forefront of partnership discussions.

*Coker Group has assisted numerous organizations in implementing various employmentlite arrangements. Contact Max Reiboldt at [mreiboldt@cokergroup.com](mailto:mreiboldt@cokergroup.com), Aimee Greeter at [agreeter@cokergroup.com](mailto:agreeter@cokergroup.com), or Alex Kirkland at [akirkland@cokergroup.com](mailto:akirkland@cokergroup.com) to learn more about these options and to explore ways this strategy may apply to your group, and visit us online at [www.cokergroup.com](http://www.cokergroup.com).*

## EXHIBITS

### EXHIBIT I. TRADITIONAL ALIGNMENT MODEL DESCRIPTIONS

Limited Integration	Moderate Integration	Full Integration
<b>Managed Care Networks (Independent Practice Associations, Physician Hospital Organizations):</b> Loose alliances for contracting purposes	<b>Service Line Management:</b> Management of all specialty services within the hospital	<b>ACO/CIN/QC:</b> Participation in an organization focused on improving quality/cost of care for governmental or non-governmental payers; may be driven by practices or hospital/groups
<b>Recruitment/Incubation:</b> Economic assistance for new physicians	<b>MSO/ISO:</b> Ties hospitals to physician's business	<b>Employment Lite:</b> Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) through which hospital engages physicians as contractors
<b>Group (Legal-Only) Merger:</b> Unites parties under common legal entity without an operational merger	<b>Clinical Co-Management:</b> Physicians become actively engaged in clinical operations and oversight of applicable service line at the hospital	<b>Employment*:</b> Strongest alignment; minimizes economic risk for physicians;
<b>Call Coverage Stipends:</b> Pay for unassigned ED call	<b>Equity Group Assimilation:</b> Ties entities via legal agreement; joint practice ownership	<b>Group (Legal and Operational) Merger:</b> Unites parties under common legal entity with full integration of operations
<b>Medical Directorships:</b> Specific clinical oversight duties	<b>Joint Ventures:</b> Unites parties under common enterprise; difficult to structure; legal hurdles	



Typically Physician-to-Physician



Typically Physician-to-Hospital



Either Physician-Physician or Physician-Hospital

*\*Includes the Physician Enterprise Model (PEM) and the Group Practice Subsidiary (GPS) model both of which allow the practice entity to remain intact even after employment of the physicians by the hospital.*

EXHIBIT II. ALIGNMENT MODELS AND COMPENSATION FRAMEWORKS

Strategy	Level	Basic Concept	Compensation Framework
<b>Managed Care Networks (i.e., IPAs, PHOs)</b>	Limited	<ul style="list-style-type: none"> <li>Loosely formed alliances</li> <li>Primarily for contracting purposes</li> <li>Limited in ability unless clinically integrated</li> <li>Being used as platform for ACO/CIN development</li> </ul>	<ul style="list-style-type: none"> <li>No true impact on pay unless in improved contracts</li> <li>Could result in distribution of incentives</li> <li>Shared savings programs within ACO/CIN framework</li> </ul>
<b>Call Coverage Stipends</b>	Limited	<ul style="list-style-type: none"> <li>Comp for personal, financial, and risk of ED coverage</li> </ul>	<ul style="list-style-type: none"> <li>Payment can be daily stipend, FFS, or hybrid</li> </ul>
<b>Medical Directorships</b>	Limited	<ul style="list-style-type: none"> <li>Payment for defined administrative services</li> <li>Must be a true need for services</li> </ul>	<ul style="list-style-type: none"> <li>Typically paid via FMV hourly rate</li> </ul>
<b>Recruitment/Incubation Model</b>	Limited	<ul style="list-style-type: none"> <li>Hospital financially supporting new recruit</li> </ul>	<ul style="list-style-type: none"> <li>Allows existing MDs to prevent compensation decrease with addition of new MD</li> </ul>
<b>Equity Model Assimilation</b>	Moderate	<ul style="list-style-type: none"> <li>Ties all entities via legal entity</li> <li>Can jointly contract with payers</li> <li>Can be with hospital and/or private group</li> </ul>	<ul style="list-style-type: none"> <li>Can result in increased profitability through better contracts</li> <li>Possible additional value through operational efficiencies</li> </ul>
<b>Provider Equity (i.e., JVs)</b>	Moderate	<ul style="list-style-type: none"> <li>JVs on specialty hospitals, ASCs, OP, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Can provide additional revenue stream to private physicians</li> </ul>
<b>Targeted Cost Objectives</b>	Moderate	<ul style="list-style-type: none"> <li>Focus to ensure delivery of cost-effective care</li> <li>Quality maintained at consistent levels</li> </ul>	<ul style="list-style-type: none"> <li>Savings shared with providers</li> <li>Based on an hourly fee, percentage, fixed fee, etc.</li> </ul>
<b>Management Services Organization</b>	Moderate	<ul style="list-style-type: none"> <li>Services provided to manage aligned entity</li> <li>Revenue cycle, HR, IT, etc.</li> <li>Can be hospital-owned, JV, or practice-owned</li> </ul>	<ul style="list-style-type: none"> <li>Can provide additional revenue strength</li> <li>Charged FMV rates for services rendered</li> </ul>
<b>Clinical Co-Management</b>	Moderate	<ul style="list-style-type: none"> <li>Provision of admin services</li> <li>Works towards certain strategic initiatives</li> <li>May include pay-for-call, directorships, etc.</li> <li>a/k/a service line management</li> </ul>	<ul style="list-style-type: none"> <li>Involves payment based on hourly rate</li> <li>Administrative and incentive payments allowed for achieving metrics</li> </ul>
<b>Professional Services Agreement</b>	High	<ul style="list-style-type: none"> <li>Allows practice to remain private, hedge payer risk</li> <li>Hospital owns receivables</li> </ul>	<ul style="list-style-type: none"> <li>Hospital pays practice on wRVU basis</li> <li>wRVU payment rates must be at FMV</li> </ul>

Exhibit II – Alignment Models and Compensation Framework (Cont.)

<u>Strategy</u>	<u>Level</u>	<u>Basic Concept</u>	<u>Compensation Framework</u>
<b>Employment</b>	High	<ul style="list-style-type: none"> <li>- Hospital owns payer contracts</li> <li>- Contract with practice for professional services</li> <li>- a/k/a Employment Lite</li> <li>- Traditional employment arrangement with hospital</li> </ul>	<ul style="list-style-type: none"> <li>- Overhead costs covered by practice from PSA payment</li> <li>- Typically includes productivity payment</li> <li>- Potential for incentive payments (i.e., quality, cost control)</li> </ul>
<b>Group Practice Subsidiary</b>	High	<ul style="list-style-type: none"> <li>- Single/Multispecialty practice functions as subsidiary</li> <li>- Wholly-owned by hospital</li> <li>- Physicians employed by subsidiary</li> </ul>	<ul style="list-style-type: none"> <li>- Entails a group income distribution plan</li> <li>- Standard entity dynamics remain at play</li> </ul>
<b>Quality Collaborative</b>	High	<ul style="list-style-type: none"> <li>- Consortium of providers in group under hospital</li> <li>- Various degrees of integration within hospital</li> <li>- Focused on furthering quality outcomes</li> <li>- Usually focused on defined population</li> </ul>	<ul style="list-style-type: none"> <li>- Internal or external funding sources determine scope and structure</li> </ul>
<b>Clinically Integrated Networks</b>	High	<ul style="list-style-type: none"> <li>- Interdependent healthcare facilities form network</li> <li>- Providers collaboratively develop clinical initiatives</li> </ul>	<ul style="list-style-type: none"> <li>- Incentive (at risk) compensation</li> <li>- Based on achievement of predetermined measures</li> </ul>
<b>Accountable Care Organizations</b>	High	<ul style="list-style-type: none"> <li>- Participating hospitals, providers, and others</li> <li>- Collaboration on quality and efficient care</li> <li>- Focused on Medicare and other patients</li> </ul>	<ul style="list-style-type: none"> <li>- Incentive (and punitive) financial impacts</li> <li>- Based on cost savings and quality</li> </ul>

EXHIBIT III. PSA MODEL COMPARISON

	Global Payment PSA	Practice Management Arrangement	Traditional PSA	Carve-Out PSA (Applicable for Carved-Out Components Only)
Physicians Employed by Hospital		X		
Physicians Employed by Practice	X		X	*
Staff Employed by Hospital			X	*
Staff Employed by Practice	X	X		*
Real Estate Owned by Hospital	*	*	*	*
Real Estate Owned by Practice	*	*	*	*
Non-Ancillary Medical Equipment Owned by Hospital			X	*
Non-Ancillary Medical Equipment Owned by Practice	X	X		*
Ancillary Medical Equipment Owned by Hospital	*	*	X	*
Ancillary Medical Equipment Owned by Practice	*	*		*
Hospital/Hospital Affiliate Physician Benefit Plans Utilized		X		
Practice Physician Benefit Plans Utilized	X		X	*
Hospital/Hospital Affiliate Billing Tax ID Used	X	X	X	X
Practice Billing Tax ID Used				
Hospital/Hospital Affiliate Retains A/R (post-alignment)	X	X	X	X
Practice Retains A/R (post-alignment)				
Managed Care Contracting Negotiations Completed by Hospital	X	X	X	X
Managed Care Contracting Negotiations Completed by Practice				
<i>*Depends on negotiated agreement</i>				